



SUBJECT: **EMERGENCY DEPARTMENT APPROVED
FOR PEDIATRIC (EDAP) STANDARDS**

REFERENCE NO. 316

PURPOSE: To establish minimum standards for the designation of Emergency Departments Approved for Pediatrics (EDAP). These Emergency Departments (ED) provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 14

DEFINITIONS:

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA), including an examination designed to assess the knowledge, skills, and experience necessary to provide quality patient care in a particular specialty.

Board Eligible (BE): Successful completion of a residency training program with progression to board certification based on the timeframe as specified by the ABMS or AOA.

Department of Children and Family Services (DCFS): A mandated component of Emergency Response Services, administered by the Los Angeles County Department of Children and Family Services. The Child Protection Hotline (CPH) intake evaluation staff is responsible for assessing any referral, whether verbal or written, which alleges child abuse, neglect, or exploitation to determine whether an in-person investigation and consultation is required.

Emergency Department Approved for Pediatrics (EDAP): A licensed basic or comprehensive emergency department (ED) that is designated by the Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system. These EDs provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures.

EDAP Medical Director: A qualified specialist in Emergency Medicine (EM) or Pediatric Emergency Medicine (PEM), also referred to as the Physician Pediatric Emergency Care Coordinator.

Emergency Nursing Pediatric Course (ENPC): Two-day course developed by the Emergency Nurses Association (ENA) that provides core-level pediatric knowledge and psychomotor skills needed to care for pediatric patients in the emergency care setting.

Designated Pediatric Consultant: a qualified specialist in pediatrics and/or pediatric subspecialty.

EFFECTIVE: 1985
REVISED: 01-01-20
SUPERSEDES: 07-01-18

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Pediatric Advanced Life Support (PALS): Pediatric resuscitation course that is recognized by the EMS Agency and valid for two years (e.g., American Heart Association, American Red Cross).

Pediatric Advisory Committee (PedAC): Acts in an advisory capacity to the EMS Agency and is responsible for all matters regarding pediatric care and policy development pertinent to the practice, operation, and administration of prehospital care, emergency departments, and pediatric intensive care units (PICU). Committee reviews, evaluates, and makes recommendations on EMS issues impacting the pediatric population.

Pediatric Emergency Course (PEC): Two-day course, with topics pre-approved by the EMS Agency, that provides knowledge about the acutely ill and injured child, and a minimum of 14 hours of Board of Registered Nursing (BRN) approved continuing education.

Pediatric Intensivist: A qualified specialist in Pediatric Critical Care.

Pediatric Liaison Nurse (PdLN): A Registered Nurse currently licensed to practice in the State of California and appointed by the Hospital to coordinate pediatric emergency care, also referred to as Nurse Pediatric Emergency Care Coordinator.

Pediatric Medical Center (PMC): A licensed acute care hospital that is designated by the EMS Agency to receive **critically ill** pediatric patients via the 9-1-1 system based on guidelines outlined in Reference No. 510, Pediatric Patient Destination.

Pediatric Patient: In the prehospital setting, is a child who is 14 years of age or younger.

Pediatric Trauma Center (PTC): A licensed acute care hospital that is designated by the EMS Agency to receive **injured** pediatric patients via the 9-1-1 system based on guidelines outlined in Reference No. 506, Trauma Triage. These centers provide tertiary pediatric care and serve as referral centers for critically injured pediatric patients.

Promptly Available: Able to be physically present in the ED within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, should not have a measurable harmful effect on the course of patient management or outcome. Hospital guidelines shall be established that address response time for on-call physicians.

Qualified Specialist: A physician licensed in the State of California who has become BC or BE in the corresponding specialty by American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).

Sexual Assault Response Team (SART) Centers: A center specializing in forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 120 hours), which has the capabilities of providing comprehensive medical and psychological forensic examinations and consist of a knowledgeable staff whose training, expertise, and state-of-the-art equipment exceeds the community standards.

Telehealth: The remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone media.

POLICY:

I. EDAP Designation / Re-Designation

- A. EDAP initial designation and EDAP re-designation is granted for a period of three years after a satisfactory review by the EMS Agency.
- B. The EMS Agency reserves the right to perform scheduled site visits or request additional data of the EDAP at any time.
- C. The EDAP shall immediately provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the EDAP Standards, including structural changes, relocation of ED and change in pediatric inpatient resources.
- D. The EDAP shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw from the EDAP program.
- E. The EDAP shall notify the EMS Agency within 15 days, in writing of any change in status of the EDAP Medical Director, ED Nurse Manager/Director, Designated Pediatric Consultant, or Pediatric Liaison Nurse (PdLN) by submitting the Notification of Personnel Change Form (Reference No. 621.2).
- F. Execute and maintain a Specialty Care Center EDAP Designation Agreement with the EMS Agency.

II. General Hospital Requirements

- A. Licensed by the State of California Department of Public Health (CDPH) as a General Acute Care Hospital, and
 - 1. Maintain a special permit for Basic or Comprehensive Emergency Medical Service; and
 - 2. Accredited by a Centers for Medicare & Medicaid Services (CMS) recognized Hospital Accreditation Organization.
- B. Appoint an EDAP Medical Director.
- C. Appoint a PdLN and provide non-clinical time to perform duties based upon the ED's annual pediatric volume:
 - 1. Low <1,800
 - 2. Medium 1,800 – 4,999
 - 3. Medium-High 5,000 – 9,999
 - 4. High >10,000 (highly recommend 1 full time equivalent)
- D. Hospital shall have a mechanism to track and monitor pediatric continuing education, including PALS, of pertinent staff.
- E. Pediatric Interfacility Transfer

Establish and maintain a written Interfacility Consultation and Transfer

Agreement for tertiary or specialty care, which shall include, at a minimum, the following:

1. A plan for subspecialty consultation (telehealth or on-site) 24 hours per day.
2. Identification of transferring and receiving hospitals' responsibilities in accordance with Emergency Medical Treatment and Active Labor Act (EMTALA).
3. A process for selecting the appropriately staffed transport service to match the patient's acuity level.

III. EDAP Leadership Requirements

A. EDAP Medical Director

1. Responsibilities:
 - a. Oversee EDAP quality improvement (QI) program and monitor to ensure adherence to the EDAP standards.
 - b. Promote and verify adequate skills and current knowledge of ED staff physicians and mid-level practitioners in pediatric emergency care and resuscitation.
 - c. Participate in a multidisciplinary ED and pediatric committees (if applicable) to ensure that pediatric care needs are addressed and communicated across disciplines.
 - d. Liaison with PMCs, PTCs, other hospitals, prehospital care providers, and the EMS Agency to ensure pediatric care needs are addressed.
 - e. Collaborates with the ED Nurse Manager/Director and the PdLN to ensure adherence to the EDAP standards for staffing, medication, equipment, supplies, and other resources for children in the ED.
 - f. Participate in EMS Agency activities and meetings and attend a minimum of two (2) PedAC meetings per year.

B. Designated Pediatric Consultant

1. Responsibilities:
 - a. Promptly available for consultation
 - b. Participate in the development and monitoring of pediatric QI program, and pediatric policies and procedures
 - c. Collaborate with the EDAP Medical Director and PdLN as needed

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- d. May also be the EDAP Medical Director
- C. ED Nurse Manager/Director
- 1. Responsibility: provide organizational support to meet EDAP requirements and initiatives
- D. Pediatric Liaison Nurse (PdLN)
- 1. Qualifications:
 - a. At least two years of experience working in pediatrics, or in an ED that provides care for pediatric patients, within the previous five years; and currently working for the ED.
 - b. Current PALS provider or instructor certification.
 - c. Completion of a two-day PEC or ENPC every four years.
 - d. Completion of seven hours of BRN approved pediatric continuing education (CE) every two years.
 - 2. Responsibilities:
 - a. Collaborate with the EDAP Medical Director, ED Nurse Manager/Director, and Designated Pediatric Consultant to ensure compliance with the EDAP Standards, Ref. No. 312, Pediatric Liaison Nurse, and policies and procedures established by the EMS Agency.
 - b. Implement, maintain, and monitor the EDAP QI program.
 - c. Serve as a liaison and maintain effective lines of communication with:
 - 1) ED management, physicians, and personnel
 - 2) Hospital pediatric management, physicians, and personnel
 - 3) Other EDAPs and PMCs
 - 4) Prehospital care coordinators (PCCs), as needed, to follow up with pediatric treatment/transport concerns
 - 5) EMS providers as needed, to follow up with pediatric treatment and/or transport concerns
 - 6) EMS Agency
 - d. Serve as a contact person for the EMS Agency and be available upon request to respond to County business.
 - e. Ensure pediatric ED continuing education and competency evaluation in pediatrics for ED staff.
 - f. Participate in EMS Agency activities and meetings and attend a minimum of two (2) PedAC meetings per year.

IV. Personnel Requirements

A. ED Physicians

1. At least 75% of the physicians attending in the ED shall be BC or BE in EM or PEM.
2. ED Physicians who are not EM or PEM BC or BE shall have current PALS provider or instructor certification.

B. Pediatricians (applies to EDAPs with associated pediatric admission unit)

There shall be a call panel for telephone consultation and a qualified specialist in pediatrics to be available to the ED twenty-four hours per day.

C. Pediatric Subspecialty Services

Pediatric subspecialty physicians, to include pediatric intensivist, shall be available through in-house call panel, telehealth, or transfer agreements.

D. Advanced Practice Providers (Physician Assistants and Nurse Practitioners)

1. Advanced Practice Providers shall be licensed in the State of California.
2. Advanced Practice Providers assigned to the ED caring for pediatric patients must have PALS provider or instructor certification.

E. Registered Nurses

1. All RN staff in the ED caring for pediatric patients must have a current PALS provider or instructor certification.
2. All nurses assigned to the ED shall attend at least 14 hours of BRN-approved pediatric emergency education (not including PALS) every four years (e.g., PEC or ENPC).
 - a. At least one RN per shift shall have completed a two-day Pediatric Emergency Course within the last 4 years and be available for patient care. It is highly recommended that all nurses regularly assigned to the ED complete this course as well.

V. Two-Day PEC – Continuing Education

A. May be completed in-house or off-site

B. The interval between Day/Part 1 and Day/Part 2 must be completed within a six-month period. If the interval between Day/Part 1 and Day/Part 2 is greater than six months, this will only fulfill the 14-hour requirement in Section IV.E.2 above.

C. Curriculum should be selected from this broad spectrum of pediatric topics which have been pre-approved by the EMS Agency:

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1. Airway management
 2. Brief Resolved Unexplained Event (BRUE)
 3. Burns
 4. Child maltreatment (suspected child abuse, neglect, and sexual assault) to include the mandated reporting process
 5. Coordination of care with a SART Center for an acute suspected sexual assault victim requiring a forensic examination
 6. Death
 7. Disaster preparedness
 8. Fever
 9. Female presenting with signs & symptoms of recent delivery and no history of giving birth / newborn abandonment
 10. Human trafficking
 11. Injury prevention
 12. Medical conditions (e.g., diabetic ketoacidosis, inborn errors of metabolism, etc.)
 13. Medication safety
 14. Neonatal resuscitation
 15. Pain management
 16. Disaster management
 17. Poisonings / overdose
 18. Procedural sedation
 19. Respiratory emergencies
 20. Resuscitation
 21. Seizures
 22. Sepsis
 23. Shock / hypotension
 24. SIDS/SUID
 25. Special health care needs
 26. Submersions
 27. Surgical emergencies
 28. Trauma
 29. Triage

- D. A copy of the course flyer, with agenda, shall be sent electronically to the EMS Agency Pediatric Program Coordinator no later than eight weeks before the scheduled course.

VI. Ancillary Services

A. Respiratory Care Practitioners (RCP)

1. At least one RCP shall be in-house twenty-four hours per day to respond to the ED.
2. All RCPs that work or respond to the ED shall have a PALS provider or instructor certification.

B. Radiology

1. The radiology department shall have pediatric-specific policies and procedures pertaining to imaging studies of children.

2. Qualified specialist in radiology must be on-call and promptly available twenty-four hours per day.
3. Radiology technician must be in-house twenty-four hours per day.
4. Provide the following services 24 hours per day/seven days per week:
 - a. Computerized tomography (CT)
 - b. Ultrasonography
 - c. Magnetic resonance Imaging (MRI)

C. Laboratory

Laboratory service shall have pediatric-specific policies and procedures pertaining to laboratory studies of children, including, but not limited to, obtaining samples, and microtechnique for small or limited sample sizes.

VII. Policies and Procedures

The hospital shall develop and maintain, at minimum, the following policies and procedures pertaining to the emergency care of children. Multiple required elements may be incorporated into one policy (e.g., Care of the Pediatric Patient in the ED).

A. Weight and Vital Sign Measurement:

1. Vital signs shall be obtained and recorded at triage for all children. The policy shall include age-appropriate methods to obtain temperature, heart rate, respiratory rate, and pain scale.
2. Blood pressure and pulse oximetry monitoring shall be available for children of all ages. Optimally, blood pressure and pulse oximetry should be assessed on all children and shall be measured on all children requiring admission or transfer. Exceptions must be addressed in policy and monitored.
3. All pediatric weights shall be recorded in kilograms upon arrival to the ED:
 - a. Children shall be weighed in kilograms. For children who require emergency stabilization or those who cannot be safely weighed, a length-based resuscitation tape may be used to estimate weight in kilograms. The weight shall be recorded in a prominent place on the medical record such as with the vital signs.
 - b. Scales used to weigh children must be configured to display weights only in kilograms.
 - c. Electronic medical records shall only allow for weight entries in kilograms.

B. Pediatric patient safety in the ED (e.g., environment of care)

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- C. Immunization assessment and management of the under immunized patient
 - D. Mandated reporting of child maltreatment (suspected child abuse, neglect, and sexual assault)

The Child Protection Hotline (CPH) operates 24 hours per day, 7 days a week. The 24-hour number (1-800-540-4000) is staffed by employees of the DCFS and responsible for screening calls from the community related to issues of child abuse and neglect. In the event, the volume calls received by CPH exceed the number of social workers available, an overflow/call back provisional number (not an official reporting number) is given to the caller. The caller is responsible for re-contacting CPH to make a referral to ensure the mandated reporting process is initiated and completed.

- 1. An immediate, or as soon as practically possible, verbal telephone report shall be made to Child Protection Hotline (CPH) and/or law enforcement.
 - 2. A Suspected Child Abuse Report (SCAR) #8572 report shall be submitted to the Department of Children and Family Services (DCFS), the report may be submitted online. <https://mandreptla.org/cars.web/CallType>
 - 3. The case number or referral number shall be documented in the patient's medical record. If SCAR filed electronically, the electronic tracking number must also be documented in the patient's medical record.
 - 4. Review by the physician-on-duty to ensure that mandated reporting requirements are completed.
 - 5. Quarterly QI review of all suspected child maltreatment cases shall be conducted by Social Services and the ED to assure the appropriate recognition of and reporting processes have been completed. A checklist may be utilized to ensure complete documentation and facilitate the review.
- E. Coordination of care with a SART Center for an acute suspected sexual assault patient/victim who may require a forensic evidentiary examination or appropriate referral, the policy/procedure shall include the following (may be incorporated into the policy/procedure above):
 - 1. Patient shall receive an interview to determine whether the assault was acute (defined as occurring with the last 120 hours) which may require immediate forensic evidentiary examination or the assault occurred over 120 hours which may be appropriate for referral to a SART Center (Ref. No. 503.1). The ED may consult with a forensic nurse.
 - 2. ED nurse or physician shall notify the law enforcement agency in the appropriate jurisdiction where the crime occurred.
 - a. Collaborate with law enforcement to determine plan of care and/or forensic evidentiary examination.
 - b. Document the officer's identification, department, and badge number in the medical record.

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- c. The ED may also contact the forensic nurse for consultation or clarification regarding patient care as it relates to evidence preservation.
 - 3. Appropriate discharge and referral.
 - F. Pediatric assessment and reassessment, include identification of abnormal vital signs according to the age of the patient, and physician notification when abnormal values are obtained
 - G. Pain assessment, treatment, and reassessment, utilize developmentally appropriate pain scales (include a description of the tools used for infant and child)
 - H. Consent and assent for emergency treatment, include situations in which a parent/legal guardian is not immediately available
 - I. Do Not Resuscitate (DNR) orders/Advanced Health Care Directives (AHCD)
 - J. Death of the child in the ED and care of the grieving family
 - K. Care and safety for the pediatric patient with mental and/or behavioral health emergencies
 - L. Physical and chemical restraint of patients
 - M. Procedural sedation
 - N. Reducing radiation exposure for pediatric patients
 - O. Safe surrender of newborns
 - P. Daily verification of proper location and functioning of equipment and supplies for the pediatric crash cart, and a content listing of items in each drawer
 - Q. Family Centered Care, include the following:
 - 1. Supporting appropriate family presence during all aspects of care to include invasive procedures and resuscitation
 - 2. Education of the patient, family, and regular caregivers
 - 3. Discharge planning and instructions
 - 4. Culturally and linguistically appropriate services
 - R. Communication with patient's medical home or primary provider based on illness and severity (e.g., aftercare instructions, x-ray results, laboratory studies, as appropriate)
 - S. Transfer from the ED to another facility

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- T. A surge plan for back-up personnel in the ED
 - U. Disaster preparedness addressing the following pediatric issues:
 - 1. Minimizing parent-child separation, and methods for reuniting separated children with their families
 - 2. Pediatric surge capacity for both injured and non-injured children
 - 3. Medical and mental health therapies, and social services for children in the event of a disaster
 - 4. Disaster drills that include a pediatric mass casualty incident at least once every two years
 - 5. Decontamination
 - V. Medication safety addressing the following pediatric issues:
 - 1. Medication orders should be written clearly in milligrams per kilogram and should specify the total dose.
 - 2. Processes for prescribing, safe medication storage, and delivery should be established. Include the use of pre-calculated dosing guidelines for children of all ages.
 - 3. Involve the patient and family in the medication safety process to ensure accurate patient identification. Include patient and family education as to the rationale for the medication.

VIII. Equipment, Supplies, and Medications

- A. Pediatric equipment, supplies, and medications shall be easily accessible, labeled, and logically organized. A mobile pediatric crash cart shall be utilized.
- B. A locator chart or grid identifying the locations of all required equipment and supplies shall be developed and maintained in order for staff to easily identify location of all items.
- C. Required EDAP equipment, supplies, and medications
 - 1. General Equipment
 - a. Weight scale measuring only in kilograms for both infants and children
 - b. Standardized length-base resuscitation tape (most recent edition) or other standardized method to estimate pediatric weights in kilograms
 - c. Pediatric drug dosage reference material with dosages calculated in milligrams, micrograms, milliequivalents, etc. per kilogram (either posted or readily available)

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- d. Developmentally appropriate pain scale assessment tools for infants and children
 - e. Blood and IV fluid warmer (Rapid infuser)
 - f. Warming and cooling system with appropriate disposable blankets
 - g. Restraints in various sizes
2. Monitoring Equipment
- a. Blood pressure cuffs
 - 1) Neonatal
 - 2) Infant
 - 3) Child
 - 4) Adult arm
 - 5) Adult thigh
 - b. Vascular Doppler device (handheld)
 - c. ECG monitor/defibrillator
 - 1) ECG electrodes in pediatric and adult sizes
 - 2) Defibrillator paddles in pediatric and adult sizes, and/or; Hands-free defibrillation device
 - 3) External pacing capability
 - 4) Multifunction pads in pediatric and adult sizes
 - d. Thermometer with hypothermia capability
3. Airway Management
- a. Bag-Mask-Ventilation (BMV) device with self-inflating bag
 - 1) Infant (minimum 450ml)
 - 2) Child
 - 3) Adult
 - b. BMV clear masks
 - 1) Neonate
 - 2) Infant
 - 3) Child
 - 4) Adult
 - c. Laryngoscope handle
 - 1) Pediatric
 - 2) Adult

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- d. Laryngoscope Blades
 - 1) Macintosh/curved: 2, 3
 - 2) Miller/straight: 00, 0, 1, 2, 3
 - e. Endotracheal Tubes
 - 1) Uncuffed: size mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5
 - 2) Cuffed: size mm 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0
 - f. Stylets for endotracheal tubes
 - 1) Pediatric
 - 2) Adult
 - g. Magill Forceps
 - 1) Pediatric
 - 2) Adult
 - h. Continuous end-tidal CO₂ monitoring device for pediatric and adult patients (preferred). If not available, colorimetric CO₂ detector may be utilized.
 - i. Pulse oximeter unit with sensors
 - 1) Infant
 - 2) Pediatric
 - 3) Adult
 - j. Nasopharyngeal Airways
 - 1) Infant (sizes 12-14)
 - 2) Child (sizes 18-28)
 - 3) Adult (sizes 30-36)
 - k. Oropharyngeal Airways
 - 1) Infant (size 00)
 - 2) Child (size 0-2)
 - 3) Adult (sizes 3-5)
 - l. Clear oxygen masks
 - 1) Infant
 - 2) Child
 - 3) Adult
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- m. Non-rebreather masks
 - 1) Infant (partial non-rebreather)
 - 2) Child
 - 3) Adult
 - n. Nasal cannulas
 - 1) Infant
 - 2) Child
 - 3) Adult
 - o. Suction catheters
 - 6, 8, 10, 12 Fr
 - p. Yankauer suction tips
 - q. Feeding tubes
 - 5, 8 Fr
 - r. Nasogastric Tubes
 - 5, 8, 10, 12, 14, 16, 18 Fr
 - s. Supraglottic Airway Devices
 - 1) Neonatal
 - 2) Infant
 - 3) Child
 - 4) Adult
 - t. Difficult Airway Kit
 - u. Tracheostomy trays: optional for EDAP, required for PMC
 - 1) Pediatric
 - 2) Adult
 - v. Tracheostomy Tubes: optional for EDAP, required for PMC
 - 1) Neonatal: size mm 2.0, 2.5, 3.0, 3.5, 4.0, 4.5
 - 2) Pediatric: size mm 3.0, 3.5, 4.0, 5.0, 5.5, 6.0
 - 4. Vascular Access Equipment
 - a. Arm boards
 - 1) Infant
 - 2) Child
 - 3) Adult
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- b. IV administration sets with calibrated chambers
 - c. IV catheters
 - 16, 18, 20, 22, 24 gauge
 - d. 3-way stopcocks
 - e. Device or needle to achieve intraosseous (IO) vascular access, to include needles in the appropriate sizes for pediatric and adult patients
 - f. IV solutions, 250ml and/or 500ml bags
 - 1) 0.9 NS
 - 2) D5.45NS
 - 3) D5NS
 - 4) D10W
5. Fracture Management Devices
- a. Splinting supplies for long bone fractures
 - b. Cervical spine motion restriction equipment (e.g., cervical collar)
 - 1) Pediatric
 - 2) Adult
 - c. Spinal board with the appropriate straps
6. Specialized Trays or Kits
- a. Newborn delivery kit to include:
 - 1) Bulb syringe
 - 2) Umbilical clamps
 - 3) Towels
 - 4) Scissors
 - b. Newborn initial resuscitation equipment should be readily available, include:
 - 1) Radiant warmer or warming mattress
 - 2) BMV device with self-inflating bag and clear mask for newborns
 - 3) Umbilical vein catheters, or 5.0 Fr feeding tube
 - c. Thoracostomy tray
 - d. Chest drainage system

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- e. Chest tubes (at least one in each size range)
 - 1) Required for EDAP: (10 – 12) (16 – 24) (28 – 40) Fr
 - 2) Required for PMC: 8, 12, 16, 20, 24, 28, 36 Fr
 - f. Lumbar Puncture trays and spinal needles
 - 1) 22 g, 3 inch
 - 2) 22-25 g, 1½ inch
 - g. Urinary catheterization sets and indwelling urinary catheters
5, 8, 10, 12, 14, 16 Fr
7. Pediatric-Specific Resuscitation
- a. Immediately available drug calculation resources
 - b. The following medications must be immediately available:
 - 1) Adenosine
 - 2) Albuterol
 - 3) Amiodarone
 - 4) Atropine
 - 5) Calcium chloride
 - 6) Dobutamine
 - 7) Dopamine
 - 8) Epinephrine 0.1mg/mL (**IV administration**)
 - 9) Epinephrine 1mg/mL (**IM administration**)
 - 10) Epinephrine for inhalation
 - 11) Fentanyl
 - 12) Ipratropium bromide (Atrovent)
 - 13) Ketamine
 - 14) Lidocaine
 - 15) Mannitol or hypertonic saline
 - 16) Naloxone
 - 17) Norepinephrine
 - 18) Neuromuscular blocking agent
 - 19) Procainamide
 - 20) Sedative agent
 - 21) Sodium Bicarbonate 4.2% (or a process to obtain the drug in an emergency situation)
 - 22) Sodium Bicarbonate 8.4%

IX. Quality Improvement (QI) Program Requirements

A QI program shall be developed as per Reference No. 620, EMS Quality Improvement Program, and monitored by the EDAP Medical Director, ED Nurse Manager/Director, and PdLN, with input as needed from the Designated Pediatric Consultant.

- A. Develop a mechanism to easily identify pediatric (14 years of age and under) visits to the ED. The mechanism should be able to delineate between a 9-1-1 versus self-transport.

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- B. Identification and trending of important aspects of pediatric care requiring improvement, to include:
1. 100% medical record review by physician and PdLN of:
 - a. Deaths in the ED
 - b. Child Maltreatment (suspected child abuse, neglect, and sexual assault) to include the mandated reporting process
 - c. Transfers to higher level of care
 - d. Unscheduled/unplanned return visits to the ED within 48 hours and are admitted or transferred for continued acute care
 2. System-wide QI projects selected by the EMS Agency and endorsed by the PedAC
 3. Track and trend two (2) QI Indicators (important aspects of patient care) identified by the Medical Director and PdLN
- C. Maintain written QI plan, trending and analysis reports, agenda, minutes, and attendance rosters, these records shall be readily available to the EMS Agency for review.
- D. Complete the National Pediatric Readiness Project (NPRP) assessment annually <https://www.pedsready.org/>, and submit a copy of the NPRP Assessment Gap Analysis to the EMS Agency by February 1st of each year.
- E. Submit data as requested by the EMS Agency for quality improvement purposes to include physician-specific reviews of EMS Agency identified important aspects of care.
- X. Data Collection Requirements
- A. Participate in the data collection process established the EMS Agency.
 - B. Submit data to the EMS Agency, within 45 days of patient discharge, which shall include data elements listed in Ref. No. 652, EDAP and PMC Data Dictionary.

CROSS REFERENCE:

Prehospital Care Policy Manual

Ref, No. 216, **Pediatric Advisory Committee (PedAC)**

Ref. No. 312, **Pediatric Liaison Nurse**

Ref. No. 318, **Pediatric Medical Center (PMC) Standards**

Ref. No. 324, **SART Center Standards**

Ref. No. 506, **Trauma Triage**

Ref. No. 510, **Pediatric Patient Destination**

Ref. No. 620, **EMS Quality Improvement Program**

Ref. No. 621.2, **Notification of Personnel Change Form**

Ref. No. 652, **EDAP and PMC Data Dictionary**

Emergency Nursing Pediatric Course (ENPC)

National Pediatric Readiness Project (NPRP)

ACKNOWLEDGEMENTS

The EMS Agency EDAP Standards were first developed by the Committee on Pediatric Emergency Medicine (COPEM), which is made up of representatives from the following organizations: Los Angeles Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of the American College of Emergency Physicians (ACEP), National Emergency Medical Services for Children (EMSC) Resource Alliance, American Academy of Pediatrics (AAP)-California Chapter 2, Emergency Nurses Association (ENA), American College of Surgeons (ACS), and the EMS Agency.

The EDAP Standards have since been revised, endorsed by The Hospital Association of Southern California, and now meet or exceed the guidelines established by the Emergency Medical Services Authority (EMSA) #182: Administration, Personnel, and Policy for the Care of Pediatric Patients in the Emergency Department, and the 2009 Joint Policy Statement: Guidelines for Care of Children in the Emergency Department which was ratified by the AAP, ACEP, and the ENA.